(2) *Beneficiary notification.* The organization that receives the enrollment must provide notification that describes the costs and benefits of the new plan and the process for accessing care under the plan and the beneficiary's ability to decline the enrollment or choose another plan. Such notification must be provided to all potential enrollees prior to the enrollment effective date (or as soon as possible after the effective date if prior notice is not practical), in a form and manner determined by CMS.

(3) *Special election period.* All individuals will be provided with a special enrollment period, as described in § 423.38(c)(8)(ii).

[70 FR 4525, Jan. 28, 2005, as amended at 74 FR 1543, Jan. 12, 2009]

§ 423.34 Enrollment of low-income subsidy eligible individuals.

(a) *General rule.* CMS must ensure the enrollment into Part D plans of low-income subsidy eligible individuals who fail to enroll in a Part D plan.

(b) *Definitions—Full-benefit dual-eligible individual.* For purposes of this section, a full-benefit dual eligible individual means an individual who is—

(1) Determined eligible by the State for—

(i) Medical assistance for full-benefits under Title XIX of the Act for the month under any eligibility category covered under the State plan or comprehensive benefits under a demonstration under section 1115 of the Act; or

(ii) Medical assistance under section 1902(a)(10(C) of the Act (medically needy) or section 1902(f) of the Act (States that use more restrictive eligibility criteria than are used by the SSI program) for any month if the individual was eligible for medical assistance in any part of the month.

(2) Eligible for Part D in accordance with § 423.30(a) of this subpart.

Low-income subsidy-eligible individual. For purposes of this section, a low-income subsidy eligible individual means an individual who meets the definition of full subsidy eligible (including full benefit dual eligible individuals as set forth in this section) or other subsidy eligible in § 423.772 of this part.

(c) *Reassigning low income subsidy eligible individuals*—(1) *General rule.* Notwithstanding § 423.32(e) of this subpart, during the annual coordinated election period, CMS may reassign certain low income subsidy eligible individuals in another PDP if CMS determines that the further enrollment is warranted, except as specified in paragraph (c)(2) of this section.

(2) *Part D prescription drug plans that waive a de minimis premium amount.* If a Part D plan offering basic prescription drug coverage in the area where the beneficiary resides has a monthly beneficiary premium amount that exceeds the low-income subsidy amount by a de minimis amount, and the Part D plan volunteers to waive that de minimis amount in accordance with § 423.780, then CMS does not reassign low income subsidy individuals who would otherwise be enrolled under paragraph (d)(1) of this section on the basis that the monthly beneficiary premium exceeds the low-income subsidy by a de minimis amount. A Part D plan that volunteers to waive such a de minimis amount agrees to do so for each month during the contract year for which a beneficiary qualifies for 100 percent low-income premium subsidy as provided in § 423.780(f).

(d) *Automatic enrollment rules*—(1) *General rule.* Except for low income subsidy eligible individuals who are qualifying covered retirees with a group health plan sponsor, as specified in paragraph (d)(3) of this section, CMS enrolls those individuals who fail to enroll in a Part D plan into a PDP offering basic prescription drug coverage in the area where the beneficiary resides that has a monthly beneficiary premium amount that does not exceed the low income subsidy amount (as defined in § 423.780(b) of this part). In the event that there is more than one PDP in an area with a monthly beneficiary premium at or below the low income premium subsidy amount, individuals are enrolled in such PDPs on a random basis.

(2) *Individuals enrolled in an MSA plan or one of the following that does not offer a Part D benefit.* Low-income subsidy eligible individuals enrolled in an MA private fee-for-service plan or cost-based HMO or CMP that does not offer qualified prescription drug coverage or an MSA plan and who fail to enroll in

a Part D plan must be enrolled into a PDP plan as described in paragraph (d)(1) of this section.

(3) *Exception for individuals who are qualifying covered retirees.* (i) Full benefit dual eligible individuals who are qualifying covered retirees as defined in § 423.882 of this part, and for whom CMS has approved the group health plan sponsor to receive the retirement drug subsidy described in subpart R of this part, also are automatically enrolled in a Part D plan, consistent with this paragraph, unless they elect to decline that enrollment.

(ii) Before effectuating such an enrollment, CMS provides notice to such individuals of their choices and advises them to discuss the potential impact of Medicare Part D coverage on their group health plan coverage. The notice informs individuals that they will be deemed to have declined to enroll in Part D unless they affirmatively enroll in a Part D plan or contact CMS and confirm that they wish to be auto-enrolled in a PDP. Individuals who elect not to be auto-enrolled, may enroll in Medicare Part D at a later time if they choose to do so.

(iii) All other low income subsidy eligible beneficiaries who are qualified covered retirees are not enrolled by CMS into PDPs.

(4) *Enrollment in PDP plans that voluntarily waive a de minimis premium amount.* CMS may include in the process specified in paragraph (d)(1) of this section that PDPs that voluntarily waive a de minimis amount as specified in § 423.780, if CMS determines that such inclusion is warranted.

(e) *Declining enrollment and disenrollment.* Nothing in this section prevents a low income subsidy eligible individual from—

(1) Affirmatively declining enrollment in Part D; or

(2) Disenrolling from the Part D plan in which the individual is enrolled and electing to enroll in another Part D plan during the special enrollment period provided under § 423.38.

(f) *Effective date of enrollment for full-benefit dual eligible individuals.* Enrollment of full-benefit dual eligible individuals under this section must be effective as follows:

(1) January 1, 2006 for individuals who are full-benefit dual-eligible individuals as of December 31, 2005.

(2) The first day of the month the individual is eligible for Part D under § 423.30(a)(1) for individuals who are Medicaid eligible and subsequently become newly eligible for Part D under § 423.30(a)(1) on or after January 1, 2006.

(3) For individuals who are eligible for Part D under § 423.30(a)(1) of this subpart and subsequently become newly eligible for Medicaid on or after January 1, 2006, enrollment is effective with the first day of the month when the individuals become eligible for both Medicaid and Part D.

(g) *Effective date of enrollment for non-full-benefit dual-eligible individuals who are low-income subsidy-eligible individuals.* The effective date for non-full-benefit dual-eligible individuals who are low-income subsidy-eligible individuals is no later than the first day of the second month after CMS determines that they meet the criteria for enrollment under this section.

[75 FR 19815, Apr. 15, 2010, as amended at 76 FR 21570, Apr. 15, 2011]

§ 423.36 Disenrollment process.

(a) *General rule.* An individual may disenroll from a PDP during the periods specified in § 423.38 by enrolling in a different PDP plan, submitting a disenrollment request to the PDP in the form and manner prescribed by CMS, or filing the appropriate disenrollment request through other mechanisms as determined by CMS.

(b) *Responsibilities of the PDP sponsor.* The PDP sponsor must—

(1) Submit a disenrollment notice to CMS within timeframes CMS specifies;

(2) Provide the enrollee with a notice of disenrollment as CMS determines and approves; and

(3) File and retain disenrollment requests for the period specified in CMS instructions.

(c) *Retroactive disenrollment.* CMS may grant retroactive disenrollment in the following cases:

(1) There never was a legally valid enrollment; or

(2) A valid request for disenrollment was properly made but not processed or acted upon.